

STATE OF NEW HAMPSHIRE
BUREAU OF EMERGENCY MEDICAL SERVICES
BLS PRACTICAL EXAMINATION EVALUATOR APPLICATION

INITIAL

Date of Application: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ E-Mail Address: _____

Phone: (home) _____ (work) _____

Service Affiliation(s): _____

D. O. B. _____ S. S. # _____

NREMT# _____ Expiration: _____

Other EMT# _____ State: _____ Expiration: _____

What Region(s) would you be willing to evaluate in? I (Western), II (Southern), III (Seacoast), IV (Central), V (Northern)

BLS Practical Examination Evaluator Training & Education Program:

Date Completed: _____ Site: _____

Have you previously applied to be a BLS Evaluator? _____ If yes, Region _____ Date: _____

Note: *Copies of current EMT and PEETE. completion certificate are required with application.*

"I verify that the above information is true and accurate to the best of my knowledge. Any falsification will result in rejection or dismissal from the BLS evaluator list."

Signed: _____ Date: _____

SUBMIT APPLICATIONS TO: Karen Louis, Educational Specialist, Seacoast EMS Field Office, 37 Pleasant Street, Epping, NH 03042

Bureau use only

Region I II III IV V
BUREAU REVIEW DATE: _____

_____ Verified - Minimum one year EMT-B, I or P

Accept Deny

_____ Falsification of credentials or other documentation
_____ Failure to meet minimum requirements

Signature: _____

Print name: _____